QA 60 - Effect of Prenatal Cocaine Intake

QUESTION:

A 2 year old girl was born prematurely to a mother who used cocaine throughout her pregnancy. The child is currently in a very educated and caring home. She has a variety of issues, including difficulty sleeping (gets up 4-8 times a night), and becoming hysterical if situations, people, food, etc., are unfamiliar or strange to her. She has a variety of oral aversions, and is working weekly with an O.T. on familiarity and acceptance of new textures and consistencies of solid foods. Apparently it's a slow process. She attends play groups where snacks are served with other children. She doesn't really eat anything but observes.

Her nutrition previously consisted of whole milk and ovaltine. Occasionally she is willing to take in a few bites of solid foods. She is now drinking chocolate PediaSure which is the only flavor she is willing to drink; a large amount is consumed through the night in a bottle with mom holding her. She is NOT underweight. She actually gained a fair amount of weight between well child checks when she was consuming the ovaltine. The concern is mainly that she gets the proper balance of nutrients. Mom reports she gets very anxious about her daughter's nutrition.

The other issue is constipation. She only drinks chocolate Pediasure which is not made with fiber. Mom tried adding chocolate syrup, mixing vanilla w/fiber and chocolate together, and adding a small amount of Metamucil to the chocolate. None of these worked because it altered the taste or texture enough that she refused to drink them. We also heard about a product called Benefiber. Finances are not a serious issue for this family; however the product is manufactured by a less familiar source and must be ordered in large quantity. Sometimes she will take a little vanilla w/fiber at night.

The adoptive mom strongly feels that her daughter has no hunger drive. She has never asked for food or drink. Even when they tried having regular meals and snacks and letting her decide how much to eat or drink she would go the entire day without eating or drinking. Mom claims the bottles at night are the only way she has been able to calm her daughter down and get her to sleep for a few hours at a time. Mom did say they have gradually been able to get a tooth brush in to clean out her mouth in the morning since the bottle is used often throughout the night.

Mom appears to be fairly proactive and has experimented with a fair amount of ideas and utilized a variety of services. We talked about cutting down on the night time feedings, providing more in the daytime, and discussed working more on cup drinking. These are difficult issues that have been worked on without much success. How much should I push those issues in light of this child having been exposed to cocaine during pregnancy? I also encouraged mom to relax more at meal times to help her daughter to also relax.

Any suggestions?

ANSWER:

The situation described is difficult not only with respect to the child's needs but in terms of the enormous challenge these adoptive parents are facing. While a problem in any one

area of a child's development may be overwhelming to a parent, this family is providing for a child who in addition to being born premature is likely suffering from sensory integration issues pervasive to nearly all areas of life including sleep, socialization, and feeding. In the best of intervention possibilities with a complete multidisciplinary team, treatment may span over several years with much parental effort to avoid excessive change while their child slowly comes to better tolerate normal environmental sensations one step at a time.

As a provider it is essential to recognize, regardless of how competent a parent may be, that the cumulative stress of providing for a child with special health care needs negatively impacts the family's ability to successfully implement treatment plans over time. With this understanding, the importance of focusing treatment on both the parent and the child becomes clear. As a dietitian it is important not to focus only on nutrition specific recommendations for the child but to prioritize parental support as well. Consider the following ways a dietitian may assert and intermingle parental support with nutrition intervention.

Psychosocial Support:

Evaluation and treatment from a psychosocial professional is essential to the overall success of multidisciplinary treatment. Such an evaluation determines the strengths and weakness of a family and provides anticipatory support and guidance where and when needed. If this family has not connected with a psychosocial professional specifically for issues related to raising a child with special health care needs, a dietitian may begin a dialogue with respect to the importance of including these services to the overall outcome of treatment and well being of the family. It is also important to make this specific recommendation to the child's primary care provider and if possible help search for a social worker or psychologist in the area with expertise in feeding and pediatric special health care needs.

Encouragement:

While treating a child with chronic health care issues it is essential as a provider to applaud the slightest movement toward or accomplishment of a goal. In this respect there are two clear messages this family needs to hear repeatedly. How well these parents are providing for and coping with the significant challenges their child brings to feeding situation (and life in general). And, how impressive it is that their child despite having significant physiological obstacles is actually responding to hunger (at night) and feeding adequately to gain and grow for normal development. Because much of a parent's anxiety often lies within a fear of not providing adequately for their child, and/or a concern that their child may not be taking in adequate nutrition for normal growth and development, the above approach speaks to their fears and works to relieve the tension and anxiety parents experience at meal times.

This reassurance can be further reassured by analyzing the child's average intake of PediaSure (or other foods and beverages as applicable) and offering supplementation as needed. One thousand milliliters of Pediasure meets or exceeds the RDA for protein and major vitamins and minerals for children two years of age. If supplementation is necessary, consider Milani Foods tasteless MVI powder added to night feeds. Other MVI possibilities include 1 mil Poly-Vi-Sol, or ½ tablet Flinstones completely dissolved in 1

tsp. water (heating in a microwave help dissolve the tablet). For more information about the tasteless MVI powder call 1-800-333-0003.

Supportive Education and Guidance:

Behavioral intervention for long term nutritional goals related to a child's appetite awareness, feeding cycle, and constipation can not be pushed but is more successfully executed by supportive education and guidance for parents to act on as they are able. Behavioral change is often initially only experimental but with continued encouragement, educational guidance, and psychosocial support the family's efforts to carry out feeding recommendations become consistent. While there are frequently several nutritional issues a parent would like to have "fixed" at one time it is important to focus the family's effort onto one or two prioritized areas. The following are suggestions for further supportive education and guidance with regard to behavioral changes within this child's appetite, feeding cycle, and constipation.

Appetite awareness:

Physiologically most children have internal feelings of hunger but may not have learned to respond to these feelings in a healthy manner. Many toddlers with feeding problems have learned to ignore hunger particularly under environmental situations that provide negative sensory input. Children with sensitivities to texture, taste and social interactions often experience meal times negatively and begin refusing food early in their life.

The fact that this child is not underweight and not requiring tube feedings, suggests that she is responding to her hunger at night in the best way she can tolerate. Given the presumed amount of time that this toddler has obtained her nutrition at night, it is likely that her internal appetite cycle is now strongest during night hours and weakest during the day. Such a shift has been documented in children whose nutritional needs were solely provided at night via night time tube feedings. When the tube feedings were stopped these children continued to feel hungry at night until they were able to meet nutritional needs during the day. Explaining this can provide hope for parents who are concerned about their child's ability to feel hunger cues and their own ability to bring about a change in this cycle.

Shifting night feeds to day (a priority to improve sleep habits for this family and overall coping skills):

This goal can be best achieved by slowly diluting night Pediasure with water to reduce caloric intake at night. As night time caloric intake is reduced, day time hunger becomes stronger and the opportunity for subsequent day time intake is enhanced. For an eight ounce bottle begin dilution with 1 ounce water to 7 ounces PediaSure. Advance dilution according to the child's tolerance (+1 ounce water per week or slower is suggested). While diluting the formula, provide the same total fluid volume in night time bottles in order to avoid excessive change in night time nurturing.

Constipation:

Unfortunately there are not easy answers for this issue except to reassure parents that this issue will gradually resolve as the other goals are met. In the interim the first goal is to maintain 85-100% maintenance fluid needs (consistent with the above prioritized goal) and coordinate with the feeding specialist to incorporate pear juice into this child's

therapeutic exposure to new foods. At this age 2 ounces of pear juice in the AM and PM help significantly. Other possibilities to consider include adding 1 tsp. mineral oil to night feedings and or/other medication and stool softeners prescribed by the child's primary care provider.

References:

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2) Wolf LS, Glass RP. Feeding and Swallowing Disorders in Infancy. Assessment and Management. Therapy Skill Builders. San Antonio, Texas. 1992.
3) Ashenburg CA: Failure To Thrive: Newer Concepts in Treatment. Ross Round Tables on Critical Approaches to Common Pediatric Problems 1997: 14:28.
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